

INDUCED REMISSION THERAPY

Our Best Hope Against Cancer?

Dr Sam Chachoua has developed a safe, effective vaccine for healing cancer, AIDS and other terminal illnesses, but medical authorities continue to ignore his work and try to prevent his treatments from becoming widely known.

Part 1

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Extracted from his forthcoming book, *The Challenge, The Promise & The Cure*, to be published in 1998.

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TRUTH, LIES AND CONSPIRACIES

Cancer, AIDS, heart disease: three faces of death that devastate so many lives. Many believe that modern medicine will someday develop effective therapies. Those afflicted, their friends, family, lovers, pray that the breakthroughs will come one day soon.

Imagine that the world was offered new treatments and even cures. Newspapers, television, radio and magazines would carry images of medical triumph supported not only by hard data but by living, walking, healthy miracles. Imagine the impact this gift would have on millions of lives: the fulfillment of dreams, the awakening of hope. Try to imagine that the announcement was made, but the world slept through it. Try to picture a public reception with indifference and a medical society charged not to embrace but to destroy all embers of this success.

If the scenario is hard to picture, then don't try to imagine it but try to remember. It happened. I know. I developed the technology. I made the announcement.

I had always known that the medical system would take some time to change, to develop, but I could not have believed that the public announcement would fall on the deaf ears of victims, nor that my peers would challenge me not on the science of my achievements but with baseless rumours, lies and personal attacks. I could never have anticipated that in answering the dreams of so many, my life would turn into a nightmare.

A THREAT TO THE STATUS QUO

The summer of 1995 was the proudest in my life. Fifteen years of research and medical trials had been building up to this one moment: the triumphant return to my adopted homeland Australia, and the fulfillment of a promise I had made to myself as I watched my father die of cancer so many years before.

Investigating three previously overlooked phenomena—organ resistance, organism resistance and spontaneous remission—I had developed effective vaccines for the prevention and treatment of many killer diseases. The genesis of what I call "Induced Remission Therapy" had begun in Australia more than a decade earlier, but I had spent five years touring the world, lecturing and training doctors in hospitals and institutes. I was returning with independent proof: dramatic and overwhelming evidence that a new age of health was being ushered in. I was returning home to present my discoveries and to fund all research and development in this field.

Armed with X-rays, blood tests, preliminary data from the Colorado University Medical School, UCLA, Cedars Sinai Medical Center and undoubtedly the strongest proof: patients in remission from cancer, AIDS and heart disease—rescued after all other options had been exhausted. This should have been the realisation of my life's goals. Via the media, millions would meet the success stories and hear of my offer of A\$100,000 to initiate investigations in Australia of this new therapy. Then, suddenly, silence. All research institutes were eligible for the \$100,000 grant but none came.

I found myself suddenly in the vacuum of a media blackout. Interviews were cancelled, news stories were not run. The public returned to its comfortable staple of cancer "breakthroughs" that may come to be in the next 10 years, the almost weekly announcements from the familiar research institutes. Soon, to the public, I became a forgotten memory. To other interests, however, I was a threat that needed to be destroyed.

A direct frontal assault on Australian soil was not the way, though. I am a medical doctor in Australia; that gives me certain powers and rights. I had offered money to have my

therapies proved or disproved, and I had reached out to the public. Attacking me overtly would have raised too many questions. Backed by data from some of the world's most prestigious research institutes, I was offering my technology with no strings attached.

Australian Medical Board representatives attempted to chastise me for what they believed were obvious lies and deception. They demanded to know who had evaluated my data and where. They accused me of falsely raising hope in poor, dying individuals. It seemed okay to announce that you can cure an occasional rat and raise millions in public donations if you are an institute; however, to say that you can help people and not ask for, but *offer* money to prove your point was not quite the done thing. Interestingly, the Medical Board enquiry into my "unprofessional" behaviour was the first time I had divulged details of the contacts and institutes investigating my technology. Incredibly, within days, these centres would not only cancel their collaboration with me but also, paradoxically, begin to deny that one had ever existed.

In the USA and Mexico clinics opened up, offering my therapy but delivering heaven-knows-what to unsuspecting patients. I initiated legal action to shut them down, but then became a victim of intense personal and professional attacks as well as physical attempts on my life. I was disgusted to learn that members of UCLA and Cedars Sinai took part in my denigration, but I was in for an even greater shock. When the names of individuals from the Australian Medical Board were used against me, I asked them to intervene; they would not. It seemed that my own Medical Board was supporting the attacks, even if only by inaction.

What is even more incredible is that amongst all the lies were claims that my MB, BS (the Australian medical degree) was not that of a doctor but rather of a nurse or undergraduate. In court, American expert witnesses testified to that and the Australian Medical Board seemed to go along for the ride.

Despite incredible resistance and bias, I won the court battle—but the war to save lives still rages.

Unlike stories of conspiracies and cover-ups from long ago, this is happening *now*. I am still alive; the dream need not be lost, then mourned. The proof is there if you would only look.

I would never have imagined that the hardest part of healing cancer and AIDS would be to get people to listen.

This is my story and our dream. Please read; read and remember.

ACCELERATED DREAMS

Every child has dreams and aspirations, major contributions to make, marks to be left, fame to be found—and what feels like an eternity in which to accomplish these objectives. Curing cancer, growing up to be a hero, saving mankind—these must be some of the commonest fantasies of the young. Impossible tasks seem achievable because there is so much time—time to study, time to grow, time to prepare. Time allows for attainable fantasies, for pleasant dreams. When time is shortened by age or situation, when there is a need for rapid realisation of the dream, reality destroys fantasies and dreams are either abandoned or are often transformed into tangible despair that mourns its loss by cutting harsher than reality ever could.

My father was first diagnosed with cancer in 1975. He was

aware of the multiple myeloma (a cancer of the bone marrow) several months prior to submitting to investigations and therapy. Multiple myeloma at the time was treated only when symptomatic, as therapy was felt to decrease lifespan, so he felt no rush to confirm his diagnosis.

He also felt no rush in informing me of his condition. My brother and sister had already entered medical school; I had entered puberty. My father worried that the news would devastate me and affect my studies. Even when faced with death, his concerns were for my life and future. So much changed in the next few years. My father, the workaholic, became much more the family man; always my hero, now my best friend.

STEPPING STONES, ALTERED PERCEPTIONS

Cancer is a disease that has repeatedly thwarted a cure. To defeat it, surely one did not simply need to understand current teachings, one needed to excel. Curing cancer was not within current knowledge, therefore one needed not only to master existing technology but to surpass it.

When seen as stepping stones to achieving my dream, teachings were devoured. I top-marked in several exams and received the T. F. Ryan Roentgen Prize in physics. I tried to apply every new nugget of information to my father's situation. Biochemistry taught of new agents that could increase the efficacy of chemotherapy and radiotherapy, and of cellular toxic agents that were presented in other contexts. Review of old and new medical research often showed that these agents had been used, and failed to demonstrate efficacy. Chemical therapy of cancer was receiving such intense worldwide scrutiny that it was virtually impossible to generate an original thought or concept from within the field.

Perhaps the answer then lay in the application of unrelated technology to the cancer problem. In physics we were taught that ultrasonic waves would have different heating coefficients depending on the density of the target; that is, the harder something was, the hotter it would become when exposed to ultrasonic frequencies. Cancer was usually denser than normal tissue, and my father's cancer, being surrounded by bone, could be heated up much more so than surrounding soft tissue. Perhaps such preferential heat damage could kill the cancer.

I approached several cancer researchers. They seemed as excited as I was but cautioned me to check past publications on the subject. Thirty years previously, someone had applied that effect to cancer with marginal and occasionally harmful responses.

If preferential attacks on cancer were not the answer, perhaps protection of normal structures against toxic agents would allow for more savage attacks against cancer. I discovered entire fields of science on the topic of radioprotective and chemoprotective agents. It was almost impossible to generate an original thought within the confines of chemotherapy and radiotherapy, yet despite continued failure these modalities seemed so powerful, so alluring. Cancer was killing my father; I wanted to hit back, hard!

Searching for metabolic weaknesses; poisoning some pathway essential to cancer but not to normal cells; combining modalities of chemotherapy with each other, with radiation, with hormones—everything had previously been done and had failed.

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Cancer was seen as a disease of excess (too much smoking, radiation, pollution etc.); the generation of an evil, foreign life-form which battles and invariably destroys its host. Excess must be cut down, taken away, burned or poisoned. This logic, combined with the frustration and hatred generated by this invulnerable nemesis, had locked us into the mindset that dominates current therapies—therapies that have failed us for so long, yet which we refuse to abandon.

STANDARD CONCEPTS OF CANCER

I would like to outline the concepts that have dominated cancer research and therapies over the past few decades. Understanding failure is a useful tool in attaining success.

By definition, cancer is a rogue cell which multiplies without respect for normal systems of cellular control and develops into a mass that invades and destroys normal tissue and structures. It is a powerful, mindless beast that spreads, grows more rapidly than normal tissue and ultimately leads to the death of the host.

Cancer growth rate may be slowed or accelerated by a variety of infections. Even in its natural history, cancer growth is not constant, for during the life of the patient the disease often grows in spurts. It is not uncommon for some cancer metastases to shrink, while most increase in size.

Cancer, the "mindless beast", starts in a localised area, invades circulatory and lymphatic systems, then spreads throughout the body. Certain cancers exhibit specific patterns of spread, long held by conventional teachings to be dictated by the pattern of circulatory distribution of micro-tumour emboli. This belief furthers the concept that cancer is a rampaging monster, cast by chance to spread its deadly seeds. Passively carried by blood and lymph to their new targets, cancer cells are undifferentiated, non-specific parcels of destruction that care not where they lodge and are not part of the decision-making process in their travels to new organs.

SEARCHING FOR MISSING DEFENCES

A few observations regarding cancer in its population and age distribution are cited repeatedly in immunotherapy literature. Essentially, increased cancer incidence occurs with immunodeficiency; and age, particularly past puberty, also appears to be a promoting factor.

If one considers only these observations, one can conclude that after puberty there is a loss of some vital immune-protective agent. If only we could identify it and replenish it, perhaps we could then triumph over this living nightmare.

The most likely candidate for our source of white blood cells in shining armour seemed to be the thymus gland, a master immune-cell generator which atrophies by early teenage years. Its degeneration seemed to correlate with increased appearance of cancer.

Therapies have proliferated over the years where part or all of the thymus, its products and hormones were used to treat cancer patients. Results were marginal to non-existent, yet, of all the borderline alternative therapies, thymus supplementation persists most stubbornly. Propelled by a romantic notion, hope does not fade—even when it is a false hope.

This restricted logic may have been sound. Perhaps we had fixated on the wrong atrophied organ.

ORGAN RESISTANCE

A common observation, even in the most advanced of malignancies, is that some organs and tissues appear resistant to cancer spread and invasion. The small intestine not only resists spread but also very rarely develops primary cancer. Perhaps there is specific immunologic capacity in the small intestine that prevents cancer from developing and protects it from tumour spread.

A quick search of anatomy and immunology books revealed that the small intestine is blessed with its own immune protection in the form of lymphoid aggregates called "Peyer's patches". Much of the function of this line of defence is restricted to the small intestine and does not circulate. This could account for the cancer resistance being local.

Studies of lower animals, particularly birds, indicated that their main immune-processing organ was not the thymus but was located in their embryonic and foetal intestine. Could this part of human immunology have been delegated an unfairly low status? In the animals, their capacity to transfer immune resistance to the entire body is optimal early in life. What if human correlation exists whereby there is transfer of resistant factors between Peyer's patches (and immune responses localised to the small intestine in later life) and the rest of the body early in life?

In view of the logic supporting thymic supplementation and the hope that restoration of an atrophied organ would destroy disease, there was another interesting observation with relation to Peyer's patches. Intestinal lymphoid aggregates atrophied with age. We had been so obsessed with the thymus that perhaps we had overlooked the real saviour.

THOUGHT TO ACTION

I had yet to start medical school but spent a good deal of time at the Peter McCallum Cancer Institute in

Melbourne where my father was receiving treatment. He had introduced me to several oncologists and I approached them with my ideas. The general response was condescending but usually polite. Dr Ian Cooper, chief haematologist, was not only supportive but also advised me to formulate my ideas as an experimental protocol and present it to Dr Jose of the Immunology Department.

The reply to my preliminary correspondence was surprisingly encouraging: I was invited to address the weekly group meeting of the immunology research team. I prepared theory, protocol and an experimental design.

The presentation was informal and pleasant. Researchers from around the world had submitted protocols for review by this unit. Immunostimulants, interferon, interleukin, lymphocyte harvest pre-chemotherapy: the suggestions were complicated but the themes familiar. I had heard or read about all these concepts before; worse yet, the experiments had been done and repeated years previously. I felt encouraged; my protocol was the only original idea being presented on that day. Surely a new concept would be more appealing to a research unit on the cutting edge of technology than simple repetition of prior failures?

To demonstrate that Peyer's patches could be stimulated to produce anti-cancer activity, I proposed that lymphocytes isolated from these aggregates be tested against those taken from the spleen and other sources for efficacy against cancer. For obvious reasons I chose multiple myeloma as the cancer system to attack. An important design feature was the testing of ordinary extracts to

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check for inherent activity and the evaluation of lymphocytes exposed to the cancer during the animal's life to search for induced activity.

I was aware that the members of the unit had not been previously exposed to this approach; it was new to them. I was also aware that they were not in the least interested.

The first question I was asked was by Dr Jose, requesting the sources and literature supporting this concept as well as data on previous trials and their conclusions on this issue.

"This experiment hasn't been done before!" I claimed proudly.

"But we need to see prior work in this field," he countered.

"That is a key factor in our accepting experimental protocols!"

In that instant, I understood an intrinsic flaw in the cancer research industry. In order to realise easy acceptance of ideas and receive grants, it was important to show that you were travelling down the same well-worn path of prior investigations.

"I don't understand," I replied. "Are you telling me that you won't do this because it hasn't been done before?"

"It is hard for me to allocate funds to work lacking prior experimental and data references." (In essence, he meant "yes".)

"We have no cure for cancer; we aren't even close. How will we find it if we don't explore new avenues?" I did not mean to sound cocky, but all of my hope and courage were suddenly dissipating. I was being rejected.

"We are on a strict budget and have defined guidelines."

I would not be dismissed; my chance to save my father demanded their acceptance.

"Okay, I'll pay for it!" (The first of many times that this phrase would pass my lips, and about the only time that I would not regret it.)

Dr Jose smiled and relented. "We'll see," he said. "Go do an intensive literature search; we'll start arranging things next week. Your ideas are interesting and worth exploring."

My father, Isaac, was by now confined to a wheelchair and my mother, Catherine, catered to his every need and whim. He had been a whirlwind, an active workaholic who delighted in helping the ill. Now confined to a chair and to bed, he exhibited a spirit and attitude that I have since come to realise is far from common. Isaac wasted no time cursing his debility but would focus on how long he was able to stay in his garden, tending to his plants, or on how active and pain-free he could be on a particular day.

That day, my father and mother awaited my return from the conference with anticipation. That night, my home was filled with intense happiness, hope and prayer.

SIMPLE MIRACLES

The experiment I had proposed was amateurish in its simplicity. The small intestine dealt with foreign challenges from ingested food on a continuous basis. Mechanisms for immunologically dealing with harmful agents had to be dramatic, rapid and effective. Every time an organism entered our intestine, we did not have the luxury of mounting a slow response with temperature, lethargy and all the normal physiologic and metabolic features of an immune response. It had to be eliminated with prejudice and finality.

Neighbourhood lymphocytes in the blood and other organs

would never meet such overwhelming numbers of challenges, as several barriers needed to be passed first; their response therefore could afford to be more delayed. Immune cells from respiratory passages would also be expected to act rapidly, but they did not appear resistant to the spread and appearance of cancer. Peyer's patches would protect the small intestine against direct invasion from the large bowel cancers as well as blood-borne metastases. I reasoned that their cancer-killing ability should be visible within minutes.

Others in the laboratory were sceptical, and with reason. Data repeated from decades of studies indicated that it would take the incubation of 50,000 to 100,000 white blood cells for three days with cancer cells and immunostimulants for some of these cells to kill one cancer cell. The effect was often so subtle that radio-uptake and leakage studies had to be undertaken to detect differences. This involved incubating cancer cells with radioactive isotopes of an agent such as caesium, to allow the cancer cells to absorb it. When damaged, cancer cells would then leak the radioactive caesium and that leakage can be measured to indicate cell damage. I reasoned that the effect would be easily seen on light microscopy with oesin uptake. This technique is one where

a red dye is added to the cells. Living cells have an active pump system and patent membranes that stop dye entry, whereas damaged and dying cells would be coloured by the oesin.

Control studies using cells from Peyer's patches that had not been exposed to cancer, showed cancer viability close to 95 per cent. Spleen cells from unexposed animals did the same. Spleen cells from animals that had been carrying the cancer gave me a surprising finding of 100 per cent viability of cancer and an actual increase in cancer count after short-term incubation. It appeared that spleen extract from a diseased animal was actually promoting tumour

growth. I did not pay much attention to that finding at the time; I was searching for a cure, not riddles.

Cells from Peyer's patches of mice that had been carrying the cancer surpassed my expectations. As opposed to the 50,000 to 100,000 cells destroying one cancer cell as previously mentioned over a three-day period, it took one lymphocyte from sensitised aggregates to kill 400 cancer cells in a one-hour-or-less time period. The cancer cells would uptake the red oesin dye and soon collapse.

The experiment would be repeated over and over before I would let myself believe it, before I would show others. Exposed to a very small amount of Peyer's patch extracts, the cancer cells would turn red with embarrassment, then shrivel and die. Mass slaughter of an invulnerable enemy—it was intoxicating and delicious.

I beckoned for Dr Jose to review the carnage. With just a hint of excitement he exclaimed, "They're all dead!" He then added in standard clinical "Vulcan" coldness: "Interesting."

The following weeks were filled with more magic. Tests confirmed no toxicity to healthy cells from my lymphocyte extracts. They were able to protect animals against cancer inoculations, and single low-dose treatment was able to keep the animals living longer once they had the disease. Other cancer systems were tested, including the hepatoma rat model, with identical successes.

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FADING DREAMS

I asked when this discovery could be put to use in terminally-ill humans. "Not for a long, long time," I was told condescendingly.

None of my colleagues or superiors in the laboratory seemed to share my excitement; worse yet, they seemed to resent my success—and me, too, for that matter. Perhaps their egos were bruised. I was often reminded that I had no formal training or education in the field, whereas they had *years* of it. My work at the Clinical Sciences Building (Royal Melbourne Hospital) and the Ludwig Institute became more and more isolated.

Other affiliates and collaborators who had donated animals and lab space to me included the Department of Biochemistry at Melbourne University. Dr Schreiber, the department head, called me in to advise me personally that in the few days I had been there I had created friction as I was not qualified, paid or a member of their 'group' and that structurally they could not support another worker. I had not fought with anybody, or argued or insulted anyone. I was unpaid and, above all, my work was yielding incredible results. How could they terminate investigation on such a promising avenue? These extracts were killing cancer more effectively and more safely than anything else in history!

"It doesn't matter," Dr Schreiber replied.

Dr Jose reminded me that publication was the only way for a scientist to achieve recognition, and offered me a poster presentation at the Clinical Oncology Society of Australia (COSA) annual meeting in 1981. Hopes rekindled; I prepared for the big time. Perhaps amongst doctors, the idea of an effective therapy would be better received than in the sterile field of research.

A few months later I was standing proudly by my poster; the youngest-ever presenter of an original project at the prestigious COSA meeting. Few people stopped by my exhibit and most did so only to advise me to leave research and concentrate on my medical studies. I was simply too young and naïve, they said. "What about the work?" I asked. "Interesting," they replied, and moved on.

Most people spent their time around a diagnostic antibody exhibit. The attractive researcher's mini-skirt and plunging neckline were also on exhibit. Hell, even *I* found myself distracted by her monoclonals!

I had come with aspirations of recognition, of encountering someone who would carry the investigation where I could not: in the human field. If I had harboured any illusions of discovery, fame or acceptance, they were quickly shattered. Scientists and doctors alike had greeted me and my discoveries with the same warmth one reserves for an acute attack of haemorrhoids or outbreak of herpes.

While I found the displays worthwhile, the conferences themselves were electrifying. I learned of new techniques being used and the latest trials of hormonal agents, immunostimulants and chemotherapy. Immunotherapy remained an exciting field, whereas the latest chemotherapy evaluations were delivered in gritty, realistic and defeatist manner. Hormones were finding increasing application in general disease management. Bone damage and pain in cancer such as multiple myeloma were shown to be preventable and treatable with anabolic hormones. Just that tidbit of information was worthwhile. It represented a concrete, usable way to help my father.

During the presentations I was to strike a friendship with an oncologist who would later do his best to destroy me. It would be a recurring theme of my life. My greatest enemies would always start as respected friends.

When I suggested to my father's oncologist that anabolic hormones be added to strengthen his bones and diminish his pain, he became annoyed. I had stepped on his toes by daring to suggest a therapy. Had I hurt his ego? Was there a better way to ask him? Who cares? I just wanted the best for my father. He refused to recommend it and my father refused to try anything his specialist did not recommend.

In one presentation I managed to offend my father's doctor and be ignored by virtually all others. I had presented a technology for curing cancer, and no one cared.

EGOS AND LIES IN THE HEALING ARTS

One of modern medicine's greatest achievements is the claim that no one needs to suffer, for there is supposedly no pain that cannot be eliminated by modern pharmaceuticals. That is perhaps true even in severe terminal pain, if one does not mind existing instead of living; existing with clouded perceptions, blunted emotions, a drug-induced stupor; a waking coma where you struggle to comprehend the world racing around you, where you try to communicate but mouth gibberish, where you dig deep, searching for the spark, the joy, the will to continue but find not even a memory of it.

This desperation, this depression, this torment, this torture is often the price paid for physical comfort. "We can prevent suffering in terminal disease" is a statement often made by a medical fool more concerned with perpetuating and reaffirming his illusions of godhood without any regard for reality.

Cancer is nothing if not relentless. Chemotherapy and radiotherapy had failed to arrest the progress of my

father's disease. As the multiple myeloma spread its physical domination, shattered my father's skeleton and destroyed his immune function, fractures, recurrent infections and pain, constant pain, became features of his life. As he lay bedridden with bone compression, multiple rib breaks and a disintegrating pelvis, my father refused painkillers except at night so that he could sleep. He would not permit any loss of mental clarity during his waking hours: time was short and he wanted to live it, experience it fully. With his body deteriorating, his mind remained the only undesecrated sanctuary, haven, drive to continue. He would not allow this most cherished possession to be tainted; he would not allow his loved ones to see him as anything less than the best he could be.

I was beginning to have major problems at medical school. I could not see the relevance of many topics, nor fathom the time-wasting techniques in teaching other subjects. We learned, for example, how to launch a projectile into orbit around Jupiter (useful knowledge if your practice caters for outer-space aliens and you wish to post them a prescription; of course that would necessitate a pharmacy on Uranus, which could prove uncomfortable). Plutonium purification in the manufacture of nuclear warheads was another priceless inclusion in our study of the healing arts. Important topics were noted by their absence. Preventive medicine was never discussed. In the late 1970s and early 1980s,

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when I undertook my formal medical studies, diet and nutrition were considered alternative heresy.

The study of anatomy was done in a particularly inefficient manner. We were given cadavers to dissect for two years. A group of eight students would spend hours, scalpels in hand, digging at a corpse, hoping to find and trace nerves and arteries to their origins and distributions. Dead bodies do not handle the same as living tissue, and rarely look the same as in book illustrations. I studied my anatomy from a book. Much more could have been learned had each group been assigned one person who was well-trained and who could have guided and educated us. My memories of these sessions are ones of the stench of formalin, of a student eating someone's biceps on a dare, and of others skipping rope using a corpse's small intestine or playing football with a hardened lung. This abhorrent lack of respect for men and women who had donated their bodies to science and medicine sickened me.

MEDICAL RESEARCH: STAGNANT, DIRECTIONLESS

In this era of genetic engineering and daily promises of medical marvels, it is hard to imagine a period where innovative thought seemed to be at a standstill; yet back then, as now, in the playing fields of clinical trials, one finds variations of intricate protocols and slight modifications of rules and tools to search for slightly improved responses from the same tired players: surgery, radiation and chemotherapy. This points to the stagnant nature of *real* options available to the public.

As a medical student, I was now becoming exposed to rigid, inhumane insanity often associated with clinical trials and questionable measures of success. Only in cancer, for example, would a chemotherapeutic agent being evaluated be considered a success if it shrank a cancer mass, even if it shortened patient survival.

Decades ago, hospitals had carried out unethical and repulsive procedures in the name of science. Pregnant women were injected with high doses of radioactive isotopes to gauge the effect on embryos; prisoners' testicles were irradiated to study changes; relatives were inoculated with patients' cancers to study their response (at least one case of cancer transfer and death of a patient's mother occurred).

Modern-day inhumanity was present, but not quite as overt. It lay in protocol objectives and structures.

I remember the case of a patient, a 22-year-old mother, who entered a monitored trial situation where she was slotted into the hormone-blocker evaluation group. This breast cancer study was designed to evaluate survival with various treatment options: surgery alone (localised), surgery alone (extensive), with radiation, with chemotherapy, with hormonal blocker therapy, with combinations of the preceding.

This data had already been gathered to reasonable precision from studies too numerous to mention worldwide, and certain guidelines for combinations had been enforced for many years. This particular design protocol did not allow for such flexibility. How could we achieve accurate readings if we contaminated one group with the therapy of another group?

The cruelty of the last statement could be seen in the plight of the patient referred to above. Having been assigned to the hormone group, other therapy was withheld—even when it became

obvious that it was not working, and spreading cancer had broken several bones in her spine. (This was not an unusual occurrence in breast cancer. The standard therapy of the time, which remains to this day, is the use of radiation to allow for fracture-healing and to resolve the associated pain. This was denied her; actually, never offered, for the 'sake' of the trial.) The insanity of this situation must be restated: this trial was confirming many others which had already outlined the relative merits of therapy. Why this theme of repetitive rediscovery of the known, regardless of human consequence? Because it gives the illusion of work, progress and motion in a stagnant cesspit of medical impotence.

In Australia, the natural health revolution had only just begun and was struggling for acceptance. The adamant claims of this new field of medicine were both inspiring and confusing. The response from conventional medicine was cutting. Alternative medicine was deemed fraudulent and rejected outright, its practitioners shunned and persecuted. Disgrace and deregistration awaited doctors who preached or practised its beliefs.

Supporters of this emerging field dealt in an inexact science, yet the detractors refused to carry out investigations to disprove the claims of alternative medicine. What resulted was a slinging match with a confused public as the victim. Patients were often punished if they saw a naturopath or asked a doctor advice on supplements; they would be treated curtly, and it was not unusual

for the doctor to refuse their ongoing care. New options had been thrust onto patients, yet proof of efficacy was as lacking as proof of inefficacy.

My mother and I had been searching constantly for anything in research, folklore or overseas programs. The sudden influx of claims from natural medicine brought a range of new modalities to try: mind power, herbs, vitamins, vegetarianism, macrobiotics. My father tried them all, to no avail.

Fasting, juices, meditation, simple do-it-yourself techniques with a uni-

versal appeal could restore a person's capacity to help themselves against a condition so foreign, so overwhelming that grown adults would revert to child-like dependency on their doctors. Even if only of marginal efficacy in the physical long-run, the psychological advantage of regaining some measure of control of one's life was a feature conventional medicine could not compete with. There was also a link that had only been hinted at previously. Alternative medicine heavily promoted the concept that proper activation of immune function could eliminate cancer—again, an empowering concept.

Perhaps in an effort to compete with the new challenger, or perhaps finally disgusted with the toxic failures called "standard therapy", the powers-that-be launched a major thrust into immunotherapy. I was part of the "IF" generation. Conventional medicine brought out a new warrior, an immunostimulant called "interferon"—the "IF" drug. I cannot claim to know or understand what changes the emphasis of investigative pathways in modern medicine, only to say that the industry is particularly well tuned to public views and needs. In the 1970s it was immune function, so interferon and interleukin occupied the forefront of research for a decade or so. In the 1980s the public cried out for natural medicine, so Taxol, a natural extract, was released.

My memories of these sessions are ones of the stench of formalin, of a student eating someone's biceps on a dare, and of others skipping rope using a corpse's small intestine or playing football with a hardened lung.

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If the above passage alluded to a sinister, manipulative arm to the industry, it is because I believe it to be inherent in this field. Interferon, hailed as the new champion in the 1970s, had actually been discovered at least 50 years previously and then shelved. Why turn to it now unless the above were true? Public manipulation and public gullibility are extreme in many areas; cancer, however, leads the field.

STOLEN HOPE

The interferon onslaught was savage. Newspapers, magazines, television and radio programs were at saturation levels with details of miraculous cures. Like a well-oiled machine, the Cancer Institute announced it would commence interferon trials; then, soon after, hospital fundraising events were commenced. This 'dance' of announcing breakthroughs, then a program for implementation followed by appeals for public donation, was monotonous and obvious, year after year.

Many controversial figures have been accused of preying on desperate victims and profiting from false hope. With

decades of failure behind them but excellent marketing and publicity, with daily announcements of breakthroughs and assurances of imminent success, with billions raised within this format, could the cancer industry not also be accused of the same? Yesterday's heroes fade into oblivion and new hopeful contenders are found to blaze in glory for a time, then fail. They may fail in living up to therapeutic expectation but always succeed in maintaining the illusion of dynamic progress and in raising phenomenal income.

Interferon was showing initial remarkable activity in several cancer types; most importantly, and repeatedly, cases of advanced multiple myeloma were shown recovering with this new therapy. My father's hospital had announced that it would investigate its efficacy in the treatment of multiple myeloma. A dream come true, a hope reignited!

My father was a doctor. He had worked at the Peter McCallum Cancer Institute and was on first-name basis with most of the specialists there. He was also one of few long-term survivors of multiple myeloma at that hospital, so surely he would be one of those enrolled in the trial now that all other

therapies were failing him.

Reality hardly ever fulfils all your dreams and prayers. It is also not usually as needlessly cruel as it was to my father. Following months of anticipation and planning into what had seemed a bleak future, we awaited notification of the interferon trial. My father was not accepted.

In medical trials, patient selection is often optimised for demonstrating good results. The healthier the patient, the more likely they are to survive the trial (no point investing in someone who may die prior to accumulation of data), and the more likely they are to make the product look good. My father was a risk. Death loomed closer; cancer laughed and marched on, its progress accelerated by a weary body and a spirit shattered not by disease but by hope that was taken away.

Editor's Note:

We will continue this story next issue with detailed coverage of Dr Sam Chachoua's Induced Remission Therapy.

VIDEOS AVAILABLE:

Two videos on Dr Chachoua's work are now available. Contact your nearest NEXUS office, or order from the web page: www.peg.apc.org/~nexus/chachoua.html